Maternal Infant Health Program (MIHP)
CYCLE 6 CERTIFICATION TOOL
August 1, 2016 through February 1, 2018

1. MIHP provider name		
2. MIHP coordinator name		
3. Date of certification review		
4. Name of reviewer/credentials		
5. Maternal caseload at time of review		
6. Infant caseload at time of review		
7. Number of transfers in current caseload		
8. Number of closed charts reviewed for billing compliance	**Maternal**	**Infant**
9. Number of open charts reviewed for billing compliance (if not enough closed charts since last review)	**Maternal**	**Infant**
10. Number of closed charts reviewed for program compliance	**Maternal**	**Infant**
11. Number of open charts reviewed for program compliance	**Maternal**	**Infant**
12. Records reviewed dated from (date of previous review)		
13. Date all pre-review materials due to reviewer		
14. Date all pre-review materials received by reviewer		
15. Number of professional staff (not including coordinator)		
16. Number of professional staff participating in staff interview (not including coordinator)		

Note: The indicators in this tool are based on the *Medicaid Provider Manual* and the *MIHP Operations Guide*. An asterisk denotes one of the four MIHP critical indicators (#2, #26, #27, and #56).

Forms

---

1. **MIHP providers must use required standardized forms developed by MDHHS. At a minimum, the data elements included in these forms must be maintained.** *(Section 4 Forms, MIHP, Medicaid Provider Manual)*

   To fully meet this indicator:

   CHART REVIEW
   a. At least 90% of paper and electronic charts reviewed have appropriately dated versions of the required standardized forms.
   b. 100% of electronic health records reviewed have forms with the same data elements in the same order as in the required standardized forms.
   c. 100% of charts reviewed have no forms on which data entries have been inappropriately altered (e.g., whiteout has been used; words have been crossed out without initialing/dating; etc.).

   ☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

   Findings:

Sufficiently Detailed Clinical Record

***2. The clinical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed.** *(Section 15.7, Clinical Records, General Information for Providers, Medicaid Provider Manual)* **Providers must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries.** *(Section 15, General Information for Providers, Medicaid Provider Manual.*

To fully meet this indicator:

CHART REVIEW

At least 80% of *Professional Visit Progress Notes (MIHP 011)* reviewed are complete, accurate, and legible with respect to each required data field, reflecting the *POC Part 1* and/or the *POC Part 2*.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Signed Consents

3. A potential client must sign the *Consent to Participate in Risk Identifier Interview/Consent to Participate in MIHP* and the *Consent to Release Protected Health Information* before the *Risk Identifier* is administered. *(Obtaining Consents Prior to Administering the Risk Identifier, Chapter 8, MIHP Operations Guide)*

To fully meet this indicator:

CHART REVIEW

a. 100% of charts reviewed have consent forms that were signed before the *Risk Identifier* was administered and are complete and accurate with respect to each data field, including:
   1) *Consent to Participate in Risk Identifier Interview/Consent to Participate in MIHP (MIHP 406, 407)*.
   2) *Consent to Release Protected Health Information (MIHP 404, 405*).

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Requested Medical Records Are Available

4. **Providers must provide requested medical records. Agencies should have a single, complete chart that is accessible to all agency and State staff. The chart should be all electronic or all paper forms. Agencies may choose to have a working chart with copies of forms, but the official chart should be complete and remain in the office.** *(Maintenance of Records, Chapter 11, MIHP Operations Guide)* **Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying all medical records, quality assurance documents, financial records, administrative records, and other documents and records that must be maintained.** *(Section 15.4, Availability of Records, General Information for Providers, Medicaid Policy Manual)*

To fully meet this indicator:

AGENCY OBSERVATION:
100% of requested records are made available for review, contains all applicable MIHP forms and are accessible to all agency, and state or federal government staff.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Timely Entry of Discharge Summary Data

5. **MIHP providers are required to enter beneficiary *Discharge Summary* data into the MDHHS MIHP electronic database. Each provider must have a process for timely, efficient entry of data into the database.** *(Required Computer Capacity to Use MIHP Electronic Database, Chapter 6, MIHP Operations Guide)*

To full meet this indicator:

COORDINATOR INTERVIEW

a. Discussion with coordinator on data entry process indicates that *Discharge Summaries* are entered into MDHHS database within required time frame.

CHART REVIEW

b. At least 80% of all (open and closed) charts reviewed indicate that *Discharge Summaries* are entered into MDHHS database within 30 calendar days after:
   1) The pregnant woman's MIHP eligibility period ends.
   2) Infant services are concluded or there are four consecutive months of inactivity, unless there is documentation on the *Contact Log* that the case is being kept open for a specific purpose and the purpose is stated.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

OB-Based Maternal Only Programs (grandfathered in)

---

6. A maternal only MIHP provider is required to serve the mother-infant in one of two ways:

a. Provide all maternal services, including the two required home visits, and after the baby is born, transfer infant to a second certified provider, per written agreement.

b. Jointly provide maternal services with a second certified MIHP provider who would conduct at least one of the two required home visits, and after the baby is born, transfer the infant to the second provider, per a written agreement. *(Mother-Infant Dyad Service Options, Chapter 4, MIHP Operations Guide)*

To fully meet this indicator:

COORDINATOR INTERVIEW

a. Discussion with coordinator indicates that maternal only provider conducts the two required maternal home visits or has a signed agreement with at least one other MIHP provider to conduct at least one of the two required home visits.

CHART REVIEW

b. At least 80% of maternal charts reviewed indicate that the first required maternal home visit was conducted within one month of enrollment in the MIHP and the second maternal home visit was conducted post-partum, or that the beneficiary refused home visits as documented in the chart.

c. At least 80% of closed maternal charts reviewed:
   1) Indicate that the maternal provider made the infant referral within one month of maternal enrollment in MIHP.
   2) Indicate that the maternal provider followed its specified process for transitioning the beneficiary to the infant services provider, as documented in the chart.
   3) Include documentation that the infant has been enrolled in infant services, infant services were refused, or it was not possible to locate the infant.

ON-SITE DOCUMENT REVIEW

d. Each signed agreement between the maternal only provider and an infant provider meets the *Guidelines for Maternal Only MIHP Providers*.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Staffing

7. **Both required disciplines must regularly conduct professional visits. The MIHP professionals with the most relevant expertise should provide the services for a particular beneficiary, based on her unique needs and goals. This means that relatively few beneficiaries will require the involvement of just one discipline, while most beneficiaries will require the involvement of two to four disciplines.** *(Section 4, Staffing, MIHP, Medicaid Provider Manual)* **Required staff for the MIHP is comprised of registered nurses and licensed social workers. Optional staff may include a registered dietitian and/or infant mental health specialist. All staff must meet the qualifications as stated in the Staff Credentials subsection of this chapter.** *(Section 5.2, Staffing, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

PRE-REVIEW MATERIALS

a. Protocol describes:
    1) How the provider arranges for RD services if provider does not have an RD on staff, identifies the RD services provider, and specifies how and under what conditions the referral to the RD is made.
    2) How the provider arranges for infant mental health (IMH) services if provider does not have an IMH specialist on staff, identifies the IMH provider, and specifies how and under what conditions the referral to the IMH provider is made.
    3) Back-up staffing arrangements whenever the MIHP is totally void of one of the required disciplines (registered nurse or social worker).
    4) How the provider ensures that each beneficiary receives a visit by the RN and a visit by the SW at least one time during the course of service or there is documentation that the beneficiary refused a visit from one of the required disciplines.
b. All MIHP staff conducting professional visits meet all MIHP professional requirements as outlined in the Medicaid Provider Manual per review of license, registration and certification; license, registration, and certification verification; and resume reflecting experience.

STAFF INTERVIEW

c. Discussion with staff indicates they can generally describe how and under what conditions they make referrals for nutritional counseling and/or infant mental health services if there is no registered dietitian or infant mental health specialist on staff.

COORDINATOR INTERVIEW

d. Discussion with the coordinator indicates that if the MIHP was totally void of one of the required disciplines, it was for a period of less than three months and the staffing back-up plan was implemented.
e. Discussion with the coordinator indicates that all RNs and SWs listed on the *Personnel Roster* regularly conduct professional visits.

CHART REVIEW

f. At least 80% of all closed charts reviewed indicate that the beneficiary receives a visit by the RN and a visit by the SW at least one time during the course of service or there is documentation that the beneficiary refused a visit from one of the required disciplines.

ON-SITE DOCUMENT REVIEW

g. Review of personnel files and *MIHP Personnel Roster* indicates that:

1) The provider directly provides (supervises hired staff and/or independent contractors) the services of at least a registered nurse **or** a social worker; the provider directly or indirectly (via contract with another agency) provides the services of the other required discipline.
2) The MDHHS waiver approval letter and *Notice of Waiver Completion* is on file for all staff waived since the previous review.
3) The *Professional Staff Waiver Training Matrix* is also on file for all staff waived since the previous review.

h. Coordinator provides reviewer with written documentation from consultant that provider notified MDHHS within 5 business days via email when the MIHP was totally void of one of the required disciplines (registered nurse or licensed social worker) for six consecutive weeks.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

8. Providers must authorize staff members to use the State of Michigan MILogin system in order to enter data into the MDHHS database. Unauthorized staff will be denied access. *(Provider Authorization of MIHP Electronic Database Users, Chapter 6, MIHP Operations Guide)* ***Providers* must use the *MIHP Personnel Roster* form to document specific information about the qualifications of each person on the MIHP staff, including everyone who is authorized to use the State of Michigan MILogin system for purposes of entering data into the MDHHS database. *The Personnel Roster* must be updated and submitted to MDHHS within 30 days after the end of every quarter.** *(MIHP Personnel Roster, Chapter 4, MIHP Operations Guide*

To fully meet this indicator:

PRE-REVIEW MATERIALS

a. Comparison of the provider's most current *MIHP Personnel Roster* submitted pre-review to the most current roster MDHHS has on file, indicates that the roster MDHHS has on file is correct.
b. MDHHS records indicate that provider submitted updated rosters to MDHHS within 30 days after the end of every quarter (by Jan. 30, April 30, July 30, and Oct. 30) since their last review and within 10 business days of any agency personnel change.

COORDINATOR INTERVIEW

c. Discussion with coordinator indicates that:
   1) Only MIHP staff are authorized to use the MILogin system.
   2) Each MIHP staff who is authorized to use the MILogin system has own MILogin user name and password.
   3) All staff authorized to use the MILogin system are listed on the current *MIHP Personnel Roster* and submitted to MDHHS within 10 business days.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Registered Dietician Services

---

9. A physician order must be obtained before a registered dietitian may visit with the beneficiary. The physician order must be included in the beneficiary record. *(Section 1.2, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. 100% of charts reviewed which document that services were provided by a registered dietitian (RD) include an order for RD services which is signed and dated by a physician, certified nurse midwife, pediatric nurse practitioner, family nurse practitioner, physician assistant or Medicaid health plan.
b. 100% of charts reviewed with an RD standing order on file, indicate that the order was reviewed and signed by the physician, certified nurse midwife, pediatric nurse practitioner, family nurse practitioner, physician assistant or Medicaid health plan within the last 12 months.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

10. When nutrition counseling is needed, the documentation must indicate how services were provided. *(Section 1.2, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of closed charts reviewed in which a high maternal nutrition risk is identified, indicate that nutrition counseling services were provided by an RD or that a referral was offered or made, as documented on a *Professional Visit Progress Note (MIHP 011)*.
b. At least 80% of closed charts reviewed in which a high infant feeding and nutrition risk is identified, indicate that nutrition counseling services were provided by an RD or that a referral was offered or made, as documented on a *Professional Visit Progress Note (MIHP 011)*.
c. At least 80% of charts reviewed in which an RD provided nutrition counseling, clearly identify the entity that provided nutrition counseling on a *Professional Visit Progress Note (MIHP 011)*.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Contracts

11. In cases where services are provided through a contract with another agency, the contract or letter of agreement must be on file for review by MDHHS. *(Section 5.1, Criteria, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

ON-SITE DOCUMENT REVIEW
Contracts and/or letters of agreement with other agencies for billable MIHP services are current and specify the time period of the agreement, the names of the individuals providing services, and, if applicable, where the billing responsibilities lie.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Care Coordination Agreements

12. To define the responsibilities and relationship between the MIHP provider and the MHP, a Care Coordination Agreement (CCA) must be reviewed and signed by both providers. *(Section 1.4, Medicaid Health Plans, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

ON-SITE DOCUMENT REVIEW
The provider has signed *Care Coordination Agreements (CCAs)* with all of the Medicaid health plans in the service area or has documentation from the consultant stating that the consultant was notified that provider has made repeated efforts to obtain one or more missing CCAs if applicable.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

MIHP Agency Facility/Office

13. The MIHP provider's physical facilities for seeing beneficiaries must be comfortable, safe, clean, and meet legal requirements. *(Section 5.1, Criteria, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

AGENCY OBSERVATION

a. Observation of facility used by beneficiaries indicates:
    1) It affords adequate privacy for beneficiary counseling and education.
    2) It affords MIHP staff adequate privacy whenever beneficiary information is discussed.

3) It provides adequate space to meet with MIHP professionals and to accommodate state consultants and MIHP reviewers in a smoke-free, pet-free room with a large table or desk, comfortable chair, and working restroom that offers privacy.
4) All entrances, bathrooms and passageways are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs.
5) All aisles, passageways and service rooms are free of hazards, kept clean, orderly and assure staff and client safety and safe passage.
6) A stairway having four or more risers is equipped with handrails.
7) Floors, platform stair treads, and landings are maintained and free from broken, worn, splintered or loose pieces that would constitute a tripping or falling hazard.
8) There are two or more exits that permit prompt escape in case of fire or other emergency.
9) The building or structure is equipped with a fire alarm system.
10) The exits, hallways and rooms are well lit.
11) A portable fire extinguisher is located where it will be readily seen and accessible along normal paths of travel, maintained in a fully-charged and operable condition, and kept at its designated place ready to use.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

14. MDHHS has developed guidelines for providers using their place of residence as an MIHP office or who have offices in other locations where beneficiaries are not seen. These providers are required to follow the guidelines. *(Guidelines for an Office in the Provider's Place of Residence or Other Location Where Beneficiaries Are Not Seen, Chapter 6, MIHP Operations Guide)*

To fully meet this indicator:

AGENCY OBSERVATION

a. Observation of home office or office in other location where beneficiaries are not seen shows:

1) It is safe (entrances and space in the home are free of hazards and there is secure safe passage when MIHP personnel are in the home), clean and comfortable.
2) It affords MIHP staff adequate privacy when discussing beneficiary information.
3) It provides adequate space to meet with MIHP professionals and to accommodate state consultants and MIHP reviewers in a smoke-free, pet-free room with a large table or desk, comfortable chair and working restroom that offers privacy.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Reporting MIHP Enrollment to Medicaid Health Plans

---

15. The MIHP must report all new MHP enrollees to the appropriate MHP on a monthly basis or as agreed to in the Care Coordination Agreement. *(Section 5.3, Operations and Certification Requirements, MIHP Medicaid Provider Manual)*

To fully meet this indicator:

PRE-REVIEW MATERIALS

a. Protocol describes procedure for informing MHPs when their members enroll in MIHP, specifying frequency of notice and the form to be used.

ON-SITE DOCUMENT REVIEW

b. Provider presents a copy of completed collaboration form (or equivalent form) that was sent to each MHP in the provider's service area in each of the preceding three months **or** documentation from the MHP that they do not want this information.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Confidentiality

---

16. Maintain an adequate and confidential beneficiary record system, including services provided under a subcontract. HIPAA standards must be met. (*Section 5.3, Operations and Certification Requirements, MIHP, Medicaid Provider Manual*)

To fully meet this indicator:

PRE-REVIEW MATERIALS

a. Protocol describes how beneficiary's Protected Health Information (PHI) is protected from intentional or unintentional use and disclosure through appropriate administrative, technical, electronic and physical safeguards, specifying the following:
   1) A double-locking system is used in office to secure MIHP records.
   2) A double-locking system is used to transport MIHP records and in staff homes to assure there is no inadvertent access to PHI by unauthorized persons. All PHI (hard copies and stored on laptops) is transported in a locked box, preferably in the trunk of a locked car. If the vehicle used for transport does not have a trunk, the locked box containing PHI is secured in an inconspicuous location and the vehicle remains locked at all times.
   3) All electronic provider communications containing PHI are encrypted.
   4) Closed beneficiary records are maintained for seven years after the last date of service in a secure location using a double-locking system.
   5) All sub-contracts include language requiring subcontractor to meet HIPAA standards.
   6) All staff sign confidentiality agreements upon hire.
   7) All staff have a copy of the *MIHP Field Confidentiality Guidelines*.
b. Review of contracts indicates inclusion of language requiring contractors to meet HIPAA standards, including record retention requirements.
c. Review of personnel records indicates that all staff with access to PHI, including MIHP owner and/or coordinator, have signed confidentiality agreements before having contact with beneficiaries or handling PHI.

STAFF INTERVIEW

d. Discussion with staff indicates that records are stored safely during transport and in staff homes.

COORDINATOR INTERVIEW

e. Discussion with coordinator and staff indicates that records are stored safely during transport and in staff homes.
f. Discussion with coordinator indicates that electronic communications containing PHI are encrypted.

AGENCY OBSERVATION

g. Observation indicates that open and closed records are stored safely in office.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Beneficiary Grievances

---

17. The MIHP must demonstrate a system for handling beneficiary grievances. *(Section 5.3, Operations and Certification Requirements, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

PRE-REVIEW MATERIALS

a. Protocol describes:
    1) Internal review steps for addressing beneficiary grievances.
    2) How beneficiary is notified of the internal grievance procedure.
    3) How beneficiary is notified of how to contact MDHHS with a grievance.
    4) Written materials provided to the beneficiary regarding the grievance procedure at time of enrollment.

STAFF INTERVIEW

b. Staff interview indicates that staff can generally describe the protocol.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Emergency Services and Scheduling Services to Accommodate Beneficiary

---

18. The MIHP must provide for weekend and after-hour emergencies. The MIHP must schedule services to accommodate the beneficiary's situation. *(Section 5.3, Operations and Certification Requirements, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

PRE-REVIEW MATERIALS

a. Protocol describes:
    1) How beneficiaries are informed about accessing services if they have an emergency on the weekend or after hours.
    2) What beneficiaries are directed to do if they have an emergency on the weekend or after hours, including calling 9-1-1 or going to the ER.
    3) How agency ensures that there is an after-hours message with emergency information on the agency phone system.
    4) How provider ensures that home visiting services are scheduled to accommodate the beneficiary's situation.

STAFF INTERVIEW

b. Staff interview indicates that staff can generally describe the protocol.

COORDINATOR INTERVIEW

c. Discussion with coordinator indicates MIHP services are scheduled at a location and time mutually determined by beneficiary and staff (i.e., evening and weekend appointments are available).
d. Discussion with coordinator indicates that beneficiaries who can't be seen during agency's operating hours are transferred to another MIHP that can accommodate them.

ON-SITE DOCUMENT REVIEW

e. There is evidence that all beneficiaries are informed in writing how to access services if they have an emergency on the weekend or after hours.

AGENCY OBSERVATION

f. There is evidence that phone system provides after-hours emergency information, including directions to call 9-1-1 or go to the ER.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Accommodations for Limited English Proficient, Deaf and Hard of Hearing, and Blind and Visually Impaired Persons

---

19. The MIHP must provide directly or arrange bilingual services and services for the visually impaired and/or hearing impaired, as indicated. (*Section 5.3, Operations and Certifications Requirements, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

PRE-REVIEW MATERIALS

a. Protocol:
   1) Describes how provider assures that Limited English Proficient persons (Arabic or Spanish speakers), deaf and hard of hearing persons, and blind and visually impaired persons are accommodated to participate in MIHP in one or more of the following ways:
      a) Provider has staff with skills to meet beneficiary's needs (e.g., can speak Arabic or Spanish; proficient in American Sign Language (ASL); has experience with assistive technology, etc.); and/or
      b) Provider has verbal or written agreement with an identified community organization that will provide interpreter services or otherwise assist provider to help meet beneficiary's needs, or uses assistive technology devices for interpretation; and/or
      c) Provider has verbal or written agreement to transfer beneficiary to another MIHP provider who can meet beneficiary's needs.
   2) Specifies that when a beneficiary requests that a family member or friend serve as interpreter, the individual must be at least 18 years old.
   3) References the federal Limited English Proficiency (LEP) mandate. *(Executive Order 13166, August 11, 2000)*

STAFF INTERVIEW

b. Staff interview indicates that staff can generally describe the protocol.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Outreach

---

20. The organization must demonstrate a capacity to conduct outreach activities to the target population and to the medical providers in the geographic area to be served. *(Section 5.1, Criteria, MIHP, Medicaid Provider Manual)* **Any entity (MIHP provider) that offers, in writing or verbally, discounts on co-pay amounts, fax machines, computers, gift cards, store discounts and other free items, or discounts/waives the cost of medication orders if an entity uses their services:**

1. **May violate the Medicaid False Claim Act and Medicaid/MDHHS policy, which may result in disenrollment from Medicaid/MDHHS programs.**
2. **May violate the Michigan Public Health Code's prohibition against unethical business practices by a licensed health professional, which may subject a licensee to investigation and possible disciplinary action.**

(Section 6.1, Termination of Enrollment, General Information for Medicaid Providers, Medicaid Provider Manual)

To fully meet this indicator:

PRE-REVIEW MATERIALS

a. Protocol describes an outreach plan which specifies outreach activities, frequency of outreach activities, and groups/agencies selected for outreach, including potential beneficiaries, medical care providers, and other community providers who serve MIHP-eligible Medicaid beneficiaries.

COORDINATOR INTERVIEW

b. Discussion with coordinator indicates that no incentives are offered to encourage beneficiaries to enroll in MIHP.

ON-SITE DOCUMENT REVIEW

c. Review of outreach documentation indicates that outreach activities are conducted according to plan unless beneficiary referrals are received from a single, regular referral source.

AGENCY OBSERVATION

d. Review of provider web site and marketing materials, and Internet search indicate that no incentives (as outlined above) are offered to encourage beneficiaries to enroll in MIHP.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Prompt Response to Receipt of Referral

---

21. The MIHP must respond to referrals promptly to meet the beneficiary's needs (within a maximum of 7 calendar days for the infant and 14 calendar days for the pregnant woman). *(Sec 5.3, Operations and Certification Requirements, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of charts reviewed indicate that the beneficiary was contacted within 14 days after referral for the pregnant woman and 7 days for the infant.
b. At least 80% of charts reviewed in which referral was received prior to infant's discharge from the inpatient setting, indicate that beneficiary was contacted within 48 hours of hospital discharge.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Medical Care Provider Notifications

---

22. When an MIHP case is opened without the medical care provider's involvement, the MIHP provider must notify the medical provider within 14 calendar days. *(Section 2.16, Communications with the Medical Care Provider, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of charts reviewed indicate that the medical care provider was notified of the beneficiary's enrollment in MIHP within 14 calendar days, unless the MIHP is part of an OB or pediatric practice and the MIHP agency has a signed statement indicating that notification is not necessary.
b. At least 80% of charts reviewed indicate that the *Notification of MIHP Enrollment Form A Cover Letter (M020* or *I009)* is in the chart.
c. At least 80% of charts reviewed indicate that the *Prenatal Communication (M022)* or *Infant Care Communication (I010)* form is complete and accurate with respect to each required data field.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

23. The MIHP provider must keep the medical care provider informed of services provided as directed by the medical care provider or when a significant change occurs. *(Section 2.16, Communications with the Medical Care Provider, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of charts reviewed in which a significant change (domain added to *POC 2;* beneficiary transfer received by MIHP provider; emergency interventions implemented; beneficiary changed medical care provider) was documented, indicate that the medical care provider was notified of this change, unless the MIHP is part of an OB or pediatric practice and the MIHP agency has a signed statement indicating that notification is not necessary.
b. At least 80% of charts reviewed in which a significant change was documented, indicate that the *Notification of Change in Risk Factors Form B Cover Letter (M023* or *I012)* is in the chart.
c. At least 80% of charts reviewed in which a significant change was documented, indicate that the *Prenatal Communication (M022)* or *Infant Care Communication (I010)* is complete and accurate with respect to each required data field.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Risk Identifiers and MIHP Consultant Authorization for Services

---

24. The *Maternal Risk Identifier* must be completed for each pregnant woman to determine services needed through the MIHP. *(Section 2.1, Maternal Risk Identifier, MIHP, Medicaid Provider Manual)*. **The *Infant Risk Identifier* must be completed for each infant entering the MIHP to determine the services needed.** *(Section 2.2, Infant Risk Identifier, MIHP, Medicaid Provider Manual)*. **On the rare occasion when the *Risk Identifier* does not indicate the need for MIHP services but professional observation suggests the beneficiary would benefit from MIHP services, the MIHP provider must obtain written authorization from the MIHP consultant to proceed with MIHP services. Documentation must support how the beneficiary may benefit from MIHP services.** *(Section 2, Maternal Risk Identifier, MIHP, Medicaid Provider Manual)*.

To fully meet this indicator:

STAFF INTERVIEW

a. Discussion with staff indicates they can describe process for reviewing a beneficiary's entire *Risk Identifier* and score sheet before signing the *POC 3*.

COORDINATOR INTERVIEW

b. Discussion with coordinator indicates that staff checks the MDHHS database before administering the *Risk Identifier* if there is more than one MIHP operating in the service area.

CHART REVIEW

c. At least 80% of charts reviewed include the entire *Risk Identifier* and scoring results page.
d. At least 80% of charts reviewed indicate that the *Maternal or Infant Risk Identifier* visit is conducted by a licensed social worker or registered nurse before the beneficiary's *Plan of Care* is developed and before any additional MIHP services are provided, unless the beneficiary has an emergency which is documented in the chart.
e. At least 100% of charts reviewed which document that the *Risk Identifier* does not indicate a need for MIHP services, but a need is recognized through professional observation, have written authorization from the MIHP consultant to enroll the beneficiary and documentation supporting the benefit of MIHP services to this beneficiary.
f. 100% of charts reviewed which document that an infant began MIHP services over the age of 12.0 months have written authorization from the MIHP consultant to enroll the infant and documentation supporting the benefit of MIHP services to this beneficiary.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Early On and Great Start Collaborative Linkages

---

25. The MIHP must be actively linked to or be a member of the local Part C/Early On Interagency Coordinating Council, and the Great Start Collaborative Council. *(Section 5.3, Operations and Certification Requirements, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

COORDINATOR INTERVIEW

a. Coordinator describes how referrals are made to Early On.

ON-SITE DOCUMENT REVIEW

b. Great Start Collaborative (GSC) membership roster indicates that provider is a GSC member **OR** provider receives regular written communications, at a minimum quarterly, from the GSC in each county served by the MIHP.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Developmental Screening

***26. Developmental screening must be provided for all MIHP infant beneficiaries.** *(Developmental Screening, Chapter 8, MIHP Operations Guide)*. **MIHP developmental screening actually begins at program enrollment, when the Infant Risk Identifier is administered. The *Infant Risk Identifier* includes developmental screening questions from *Bright Futures*, an initiative of the American Academy of Pediatrics. Once the *Infant Risk Identifier* has been administered and *Bright Futures* screening has been repeated, if necessary, all follow-up developmental screening is conducted using the *ASQ* tools. The timing of the initial follow-up screening using the *ASQ* tools depends on the primary caregiver's responses to the *Bright Futures* questions** *(MIHP Developmental Screening Begins with the Risk Identifier, Chapter 8, MIHP Operations Guide)*. **The *ASQ-3* is used to monitor and identify issues in general infant development in the communication, gross motor, fine motor, problem-solving, and personal-social domains. The *ASQ: SE-2* is used to monitor and identify issues in infant development in the social-emotional domain.** *(Developmental Screening, Chapter 8, MIHP Operations Guide)*

ASQ Part 1 – Protocol

To fully meet this indicator:

STAFF INTERVIEW

a. Staff interview indicates that staff can generally describe the protocol.

ON-SITE DOCUMENT REVIEW

b. Protocol describes how:
   1) Staff will age-adjust for prematurity when selecting the appropriate *Bright Futures* questions (in *Infant Risk Identifier*) at the time of infant enrollment into MIHP.
   2) Coordinator assures that the appropriate *ASQ-3* and *ASQ: SE-2* age interval questionnaires are used.
   3) Coordinator assures that *ASQ-3* and *ASQ: SE-2* screenings are repeatedly conducted at the time intervals required in *the MIHP Operations Guide.*
   4) *Coordinator assures that referrals to Early On* are made when *ASQ-3* score falls below the cutoff or the *ASQ: SE-2* score falls above the cutoff.

ASQ Part 2 – Conducting and Documenting Screenings

To fully meet this indicator:

CHART REVIEW

a. At least 80% of infant charts reviewed indicate that the age-appropriate *Bright Futures* questions were used when the *Infant Risk Identifier* was administered.
b. At least 80% of infant charts which document *Bright Futures* results requiring follow-up screening within two weeks, indicate that follow-up screening was conducted.
c. At least 80% of infant charts reviewed have *ASQ-3* and *ASQ: SE-2 Information Summary* sheets.
d. At least 80% of infant charts reviewed have *ASQ-3* and *ASQ: SE-2 Information Summary* sheets that are complete and accurate with respect to each required data field.
e. At least 80% of infant charts reviewed indicate that the appropriate *ASQ-3* and *ASQ: SE-2* age interval questionnaires are used, corrected for prematurity, if applicable.
f. At least 80% of infant charts reviewed indicate that *ASQ-3* and *ASQ: SE-2* screenings are repeatedly conducted at the time intervals required in the *MIHP Operations Guide*.
g. At least 80% of infant charts document that learning activities and development guides were shared with the family when an *ASQ-3* and *ASQ: SE-2* scored close to the cutoff (in the gray area) in one or more domains.

ASQ Part 3 – Screening Follow-up

To fully meet this indicator:

CHART REVIEW

a. 100% of infant charts that document an *ASQ-3* score below the cutoff or an *ASQ: SE-2* score above the cutoff, indicate that a referral to *Early On* was made, or at least discussed with the family.
b. At least 80% of infant charts that document a referral to *Early On* was indicated but the family declined referral to *Early On* or child didn't qualify for *Early On*, indicate that learning activities were shared with the family.
c. At least 80% of infant charts with an *ASQ-3* or *ASQ:SE-2* scoring close to the cutoff (in the gray area) document that the infant was screened again in two months or document the plan to screen again in two months.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Plan of Care

---

27. *Plan of Care, Part 1

The *POC 1* is done for all beneficiaries who complete the *Risk Identifier*. It documents that the professional (RN or SW) who administered the *Risk Identifier* gave the beneficiary a *Maternal and Infant Education Packet* or information on text4baby, provided MIHP contact information, provided information on the Healthy Michigan Plan, referred the beneficiary to WIC, if applicable, and scheduled a follow-up MIHP appointment, if applicable. *(Plan of Care, Part One [POC 1], Chapter 8, MIHP Operations Guide)*.

To fully meet this indicator:

PRE-REVIEW MATERIALS

a. Protocol describes:
    1) How and when written documentation is given to beneficiaries regarding Healthy Michigan Plan.
    2) Written documentation given to beneficiaries on how and when to contact the agency.
    3) The steps taken to help beneficiaries sign up for text4baby.

CHART REVIEW

b. At least 80% of charts reviewed include a complete and accurate *Maternal Plan of Care, Part 1 (M002)* or *Infant Plan of Care, Part 1 (I002)* with:
    1) Box checked indicating that beneficiary received the entire, current standardized *Maternal and Infant Education Packet* **or** staff assisted the beneficiary to sign up for text4baby, or both.
    2) Signatures of registered nurse and licensed social worker.
    3) Signatures of registered nurse and licensed social worker dated within 10 business days of each other.

Plan of Care, Part 2

If a need is indicated, an appropriate *POC* must be developed that clearly outlines the beneficiary's problems/needs, objectives/outcomes, and the intervention(s) to address the problem(s). *(Section 2.4, Psychosocial and Nutritional Assessment-Risk Identifier, MIHP, Medicaid Provider Manual).* **The registered nurse and the licensed social worker, working together, must develop a comprehensive *POC* to provide identified services to the beneficiary and/or referrals to community agencies.** *(Section 2.5, Plan of Care, MIHP, Medicaid Provider Manual)* ***POC* implementation is client-focused, meaning that the beneficiary selects the domains that are priorities for her and that she wishes to address.** *(Plan of Care, Part Two [POC 2], Chapter 8, MIHP Operations Guide)*

To fully meet this indicator:

STAFF INTERVIEW

a. Discussion with staff indicates they can describe how they include the beneficiary in selecting domains that are priorities for the beneficiary and that she wishes to address.

CHART REVIEW

b. At least 80% of charts reviewed include a complete and accurate *Maternal Plan of Care, Part 2 (M003 - M021)* or *Infant Plan of Care, Part 2 (I003 - I007, I020, I036)* with a corresponding domain for every risk identified by the *Risk Identifier* or professional judgment.
c. At least 80% of charts reviewed in which an additional risk based on professional judgment and matching the criteria in *POC 2,* Column 2 has been documented, indicate that an additional domain is added to the *POC 2* and the date of the addition is noted in Column 1.
d. At least 80% of charts reviewed in which a risk level change has been documented, indicate that the risk level increase or decrease is based on the criteria in *POC 2*, Column 2 and that the date of the change is noted in Column 1.
e. At least 80% of closed charts reviewed indicate that the date an intervention is first implemented is noted in the *Date* Achieved space in Column 3 on the *POC 2.*

Plan of Care, Part 3
The *POC, Part 3, Signature Page for Interventions by Risk Level,* is a form used to document that the licensed social worker and the registered nurse have jointly developed the *POC 2*, concur on the interventions to be implemented, and are responsible for implementing them. The RN and SW must sign and date the *POC 3* within 10 business days of each other. *(Plan of Care, Part 3 [POC3], Chapter 8, MIHP Operations Guide)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of charts reviewed include a complete and accurate *Plan of Care, Part 3(MIHP 008)* which:
   1) Corresponds to the *POC 2*.
   2) Is signed by the registered nurse and the licensed social worker within 10 business days of each other, acknowledging that both reviewed and agreed to the *POC 2*.
   3) Is signed and dated before any MIHP services are provided, except in an emergency situation, which is clearly documented.

b. At least 80% of charts reviewed in which an additional risk domain is added to the *POC 2* after the original *POC 3* is signed, indicate that the *POC 3* is updated.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Care Coordination

---

28. The name of the care coordinator must be documented in the beneficiary's record. *(Section 2.6, Care Coordinator, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of charts reviewed indicate that the care coordinator is identified on the *POC 1* and *POC 3*.
b. At least 80% of charts reviewed indicate that if the care coordinator is changed during the course of care, it is documented on the *POC 3*.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

29. A registered nurse or licensed social worker will be identified as the care coordinator assigned to monitor and coordinate all MIHP care, referrals, and follow-up services for the beneficiary. *(Section 2.6, Care Coordinator, MIHP, Medicaid Provider Manual)* **The care coordinator is responsible for monitoring and coordinating all care provided for the beneficiary. This means the care coordinator follows up with the other professionals who are working with the beneficiary.** *(MIHP Care Coordinator, Chapter 8, MIHP Operations Guide)*

To fully meet this indicator:

PRE-REVIEW MATERIALS
Protocol describes:

a. The care coordinator's process for conducting quarterly chart reviews to determine:
    1) Whether or not the beneficiary has been seen within the last 30 days.
    2) The extent to which the *POC* is being implemented as developed and whether it needs modification.
    3) The extent to which the appropriate interventions are being implemented.
    4) Whether or not appropriate referrals have been made and followed up on.
    5) Whether or not the POC is meeting the beneficiary's needs.

STAFF INTERVIEW

b. Staff interview indicates that staff can generally describe the protocol.
c. Staff interview indicates that staff can describe when they complete care coordination chart reviews and number of charts reviewed per quarter.

COORDINATOR INTERVIEW

d. Coordinator can describe how protocol is being implemented within their agency.

CHART REVIEW

e. At least 80% of closed charts reviewed have *Maternal Forms Checklists (M001)* or *Infant Forms Checklists (I001)* that are complete and accurate.
f. At least 80% of charts reviewed indicate that a *Contact Log* is used to document attempts to contact the beneficiary (e.g., phone, text, email, letter, note on door, etc.) between professional visits, from the last professional visit to discharge, and to coordinate care.
g. At least 80% of charts reviewed indicate that visits are conducted at least monthly unless there is documentation as to why this wasn't done.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Making and Following Up on Referrals

---

30. The care coordinator must assure the family is appropriately followed and referred for needed services. *(Section 2.6, Care Coordinator, MIHP, Medicaid Provider Manual)*

A MIHP referral takes place when a professional:

1. **Discusses a particular referral source with the beneficiary, so she clearly knows what to expect. Encourages the beneficiary to seek services from the referral source.**
2. **Determines that the beneficiary wishes to seek services from the referral source.**
3. **Provides specific information about contacting the referral source in writing.**
4. **Determines if the beneficiary needs assistance to contact the referral source due to limited English proficiency, low literacy, comprehension difficulties, immobilization stemming from depression, fear or stigma related to using certain services (e.g., *Early On*, mental health services, substance abuse services, domestic violence services, etc.), or other concerns. Provides assistance in contacting the referral source, if needed.**

If the beneficiary does not wish to seek services, ask her about her reasons. If appropriate, gently encourage her to continue to think about it, explaining the potential benefits. *(Making and Following-up on Referrals to Other Supports and Services, Chapter 8, MIHP Operations Guide)*

To fully meet this indicator:

STAFF INTERVIEW

a. Staff interview indicates that staff can describe where referrals are documented and the process for follow up on referrals?

CHART REVIEW

b. At least 80% of charts reviewed indicate that referrals are being made and documented as required in the MIHP Operation Guide.
c. At least 80% of charts reviewed indicate staff follows up on at least 80% of referrals made within 3 professional visits from the date of referral.
d. At least 80% of charts reviewed indicate referral outcomes are documented on *Professional Visit Progress Notes (MIHP 011)* under "outcome of previous referrals" and include which referral is being addressed and the status of the referral.
e. At least 80% of charts reviewed which document that beneficiary scored moderate or high on the stress/depression domain, indicate that a mental health referral was made (may be an infant mental health referral) or there is documentation as to why referral was not made.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

31. Placeholder for indicator in next review cycle

Professional Visits

---

32. Address all domains that score out as high risk within the first three visits or document why this has not been done on a *Professional Visit Progress Note*. Help the beneficiary develop a written or verbal safety plan when she scores out as high risk on the depression, domestic violence, or substance abuse domain (infants only) or provide documentation that the beneficiary did not wish to develop a safety plan. *(Plan of Care Part 2 (POC 2) Implementation, Chapter 8, MIHP Operations Guide)*

To fully meet this indicator:

STAFF INTERVIEW

a. Staff can describe when to develop a safety plan.
b. Staff can describe the time limit for addressing high risk domains.

CHART REVIEW

c. At least 80% of charts reviewed indicate that all domains that scored out as high risk are discussed with beneficiary within the first three visits, unless there is clear documentation *on the Professional Visit Progress Note* stating the reason why this has not been done.
d. At least 80% of closed charts reviewed in which the beneficiary scored high risk for depression, domestic violence, or substance exposure (infants only), include documentation that a verbal or written safety plan was developed or documentation that the beneficiary did not wish to develop a safety plan.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

33. A professional visit is a face-to-face encounter with a beneficiary conducted by a licensed professional (i.e., licensed social worker, registered nurse, or infant mental health specialist) for the specific purpose of implementing the beneficiary's plan of care. A registered dietitian may conduct a visit when ordered by a physician. *(Section 2.7, Professional Visits, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

STAFF INTERVIEW

a. Staff interview indicates that staff can explain how they have knowledge of *Risk Identifier* results, the *POC 2*, and referrals made at previous visits before visiting a beneficiary.

CHART REVIEW

b. At least 80% of total number of *Professional Visit Progress Notes (MIHP 011)* reviewed indicate that staff is implementing *POC 2* interventions only for risk domains that are included in the *POC 2*.
c. At least 80% of closed charts reviewed indicate that staff addressed all risk domains included in the *POC 2* or there is documentation as to why risk domains were not addressed on the *Professional Visit Progress Note*.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

34. On average, 80% of all professional infant interventions must be in the beneficiary's home. The initial assessment visit, when the Infant Risk Identifier is completed, must be completed in the beneficiary's home at least 90% of the time. *(Section 2.9.B, Infant Services, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

STATE MIHP STAFF ADMINSTRATIVE REVIEW

a. At least 80% of the agency's infant visits are done in the beneficiary's home as indicated in the *MIHP Standardized Certification Data Report* or, if the *Data Report* is unavailable, by chart review. If a chart review is conducted, at least 80% of infant charts reviewed indicate that 80% of the visits are done in the infant's home, unless a compelling reason why a home visit is not possible is clearly documented.
b. At least 90% of the agency's *Infant Risk Identifier* visits are done in the beneficiary's home as indicated in the *MIHP Standardized Certification Data Report* or, if *Data Report* is unavailable, by chart review. If a chart review is conducted, at least 90% of the infant charts reviewed indicate that the *Infant Risk Identifier* was completed in the beneficiary's home.
c. The chart includes a written request with a written approval from the consultant for any infant who reaches the age of 18 months and continues to be served by the MIHP.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

35. An additional nine infant visits may be provided when requested in writing by the medical care provider. All visits beyond the original nine visits must have a written physician order. *(Section 2.2, Infant Risk Identifier, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of infant charts reviewed which document more than nine visits indicate that no additional visits were conducted or billed before the date of the written order.
b. At least 80% of infant charts reviewed which document more than nine visits, indicate that the reason why additional visits are required is documented on a standing order or *Professional Visit Progress Note*.
c. At least 80% of charts reviewed with a standing order authorizing additional infant visits on file, indicate that the order was reviewed and signed by the physician within the last 12 months.
d. 100% of charts reviewed which document that an infant over the age of 18.0 months received MIHP services have written authorization from the MIHP consultant to continue services and has documentation supporting the benefit of MIHP services to this beneficiary.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

36. A drug exposed infant is an infant born with the presence of an illegal drug (s) and/or alcohol in his circulatory system or who is living in an environment where substance abuse or alcohol is a danger or is suspected. The maximum of 36 professional visits and the initial assessment visit may be reimbursed for a drug-exposed infant. The provider must use the professional visit code for the first 18 visits; the drug-exposed procedure code may then be billed for up to an additional 18 visits. *(Section 2.8, Drug-Exposed Infant, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of infant charts reviewed which document use of the drug-exposed procedure code, indicate that the professional visit code was used for the first 18 infant visits.
b. At least 80% of infant charts reviewed which document use of the drug-exposed procedure code, indicate that the infant meets drug-exposed infant criteria.
c. At least 80% of infant charts reviewed indicate that the drug-exposed procedure code is not used unless a medical care provider order authorizing additional drug-exposed infant visits is found in the chart.
d. At least 80% of infant charts reviewed with a standing order authorizing additional drug exposed infant visits, indicate that the order was reviewed and signed by the medical care provider within the last 12 months.
e. At least 80% of infant charts reviewed which document use of the drug-exposed procedure code, indicate that the *Substance Exposed Code 96154 Professional Visit Progress Note (I300)* is being used for visits 19 through 36.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

37. In cases of multiple births, each infant should have a separate risk identifier visit completed. This also applies to infants in foster care where there are two infants in the same home. These separate risk identifier visits can be billed separately under each individual infant Medicaid identification number. Subsequent professional visits should be billed under each infant ID if the infants are from different families, such as with foster care families. If the infants are siblings, the visits should be "blended" visits and billed under one Medicaid ID only. The risk identifier visit and up to nine professional visits can be made to the family. A physician order is needed if more than nine infant visits are needed per family. *(Section 2.3, Multiple Births, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of infant charts reviewed which document multiple births, indicate that an *Infant Risk Identifier* has been completed for each infant and billed to the infant's Medicaid ID.
b. At least 80% of infant charts reviewed which document multiple births, indicate that separate *Infant Risk Identifiers*, *Plans of Care*, *ASQ-3s, ASQ: SE-2s*, and *Discharge Summaries* (closed cases only) are on file for each infant.
c. At least 80% of infant charts reviewed which document multiple births, indicate that *Professional Visit Progress Notes* for blended visits are on file in a family chart; or in the chart of the beneficiary whose Medicaid ID number is being used for billing purposes; or in a separate chart for each family member.

d. At least 80% of charts reviewed which document multiple births, have *Notification of Multiple Charts Open (099)* on file in each infant's chart when blended visits are being provided, unless a family chart is used.
e. At least 80% of infant charts reviewed which document multiple births, indicate that professional visits are blended and consistently billed under only one infant's Medicaid ID.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Certification Process

---

38. Prior to the review, the reviewer will examine requested documents submitted by the provider. The documents must be submitted by the provider and received by the reviewer at least 14 days prior to the scheduled onsite review. *(MIHP Provider Certification for Quality Assurance, Chapter 9, MIHP Operations Guide)*

To fully meet this indicator:

PRE-REVIEW MATERIALS

a. Provider sends requested certification documentation to the reviewer by mail only, (**not** via fax or email).
b. All pre-review documents requested are received by the reviewer no later than 14 calendar days before the onsite review.
c. All documents submitted are legible.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

39. The number of staff who must be present at the staff interview (in addition to the coordinator) depends on the size of the staff. *(MIHP Provider Certification for Quality Assurance, Chapter 9, MIHP Operations Guide)*

To fully meet this indicator:

AGENCY OBSERVATION

The number of professional staff who participate in the staff interview in person or via conference call, in addition to the coordinator, meets the applicable criterion listed below:

- Agency employing 2-3 professional staff: All must participate.
- Agency employing 4-5 professional staff: At least three must participate.
- Agency employing 6 or more professional staff: At least 50% must participate.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

40. MIHP staff persons who work directly with beneficiaries in their homes or at other community settings must carry identification (ID) cards or badges with them at all times. *(Required Identification Cards for MIHP Direct Service Staff, Chapter 4, MIHP Operations Guide)*

To fully meet this indicator:

STAFF INTERVIEW

a. Review of staff badge or card indicates staff is affiliated with MIHP provider.
b. Staff interview indicates they carry MIHP badges or cards when providing services to beneficiary.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

MIHP Home and Community Visits

---

41. For a community visit to be reimbursable, the beneficiary record must clearly identify the reason(s) why the beneficiary could not be seen in her home or in the MIHP office setting. This documentation must be completed for each visit occurring in the community setting. Visits occurring in buildings contiguous with the provider's office, in the provider's satellite office, or rooms arranged or rented for the purpose of seeing beneficiaries, are considered to be in an office setting rather than in a community setting. Visits should never be conducted in the MIHP provider's home. *(Section 2.9, Place of Service, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

At least 80% of charts reviewed which document community visits, indicate that the reason why the beneficiary could not be seen in home or office is clearly identified on the *Professional Visit Progress Note (MIHP 011)* for each and every community visit.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

42. Efforts must be made to visit the maternal beneficiary in the home. MDHHS requires one visit be made to the beneficiary's home during the prenatal period to better understand the beneficiary's background.

A second maternal home visit must be made after the birth of the infant to observe bonding, infant care and nutrition, and discuss family planning. An MIHP provider may complete and bill an Infant Risk Identifier visit separate from a maternal postpartum professional visit. A maternal postpartum professional visit may be made on the same date of service as the Infant Risk Identifier visit. Providers must document why both visits need to be on the same date of service. *(Section 2.9.A, Maternal Services, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of maternal charts reviewed indicate that at least one prenatal home visit is made or, in a clinic-based program, that the hand-off was made to the appropriate MIHP infant services provider, or there is documentation that the beneficiary declined the prenatal home visit.
b. At least 80% of closed maternal charts reviewed indicate that one post-partum home visit was made or, in an OB clinic-based program, that the hand-off was made to the appropriate MIHP infant services provider (excludes MOMS clients).
c. At least 80% of charts reviewed which document that a maternal postpartum visit and *Infant Risk Identifier* visit were made on the same day, indicate the reason why both visits needed to be on the same date of service.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Training and Education

---

43. The coordinator is responsible for disseminating information received from the MIHP state team to their professional and administrative staff. *(Coordinator Responsibility for Disseminating MIHP Information to Staff, Chapter 10, MIHP Operations Guide)*

To fully meet this indicator:

STAFF INTERVIEW

a. Staff can explain how and when:
    1) MIHP coordinator shares the coordinator emails.
    2) MIHP coordinator shares updates and training content received at the regional coordinator meetings.
    3) MIHP coordinator shares special communications, webinar announcements or other MIHP information.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

44. MIHP coordinator and professional staff must complete all of the training requirements specified by MDHHS. *(MDHHS Online Trainings, Chapter 10, MIHP Operations Guide)*

To fully meet this indicator:

ON-SITE DOCUMENT REVIEW

a. Course completion certificates for the following online trainings are on file for all professional staff and the program coordinator:
    1) *Overview of the MIHP Training Course (formerly titled MIHP Billing and Overview)*
    2) *Smoke Free for Baby and Me*
    3) *Motivational Interviewing and the Theory behind MIHP Interventions*
    4) *Alcohol Free Baby and Me*
    5) *Implementing the MIHP Depression Interventions*

6) *Reaching the Most Difficult to Reach Families: An Attachment Perspective*
7) *Infant Mental Health in MIHP (under development)*
8) *Interpersonal violence and MIHP*
9) *Intimate Partner Violence: More than Meets the Eye*
10) *Breastfeeding and MIHP*
11) *Prevention of Early Elective Delivery*
12) *Ages and Stages Questionnaires (3rd Edition) and Ages and Stages Questionnaires: Social-Emotional (Separate ASQ-3and ASQ: SE-2 are under development and will replace this training when complete)*
13) *Infant Safe Sleep for Health Care Providers*

b. Signed *Notice of New Professional Staff Training Completion* is on file for all staff hired/contracted since 10/01/12.
c. MDHHS attendance certificates indicate coordinator or designee attended all required state coordinator trainings (in person and webcasts) since previous review.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Childbirth and Parenting Education

---

45. First time mothers must be encouraged to complete the childbirth education (CBE) course. *(Section 2.11, Childbirth Education, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW
At least 80% of closed maternal charts which document that beneficiary is a first-time mother, indicate on a *Professional Visit Progress Note (MIHP 011)* that beneficiary was encouraged to attend CBE classes.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

46. In unusual circumstances (e.g., beneficiary entered prenatal care late or is homebound due to a medical condition), childbirth education may be provided in the beneficiary's home as a separately billable service. Case records must document the need for one-on-one childbirth education and where services were provided. *(Section 2.11, Childbirth Education, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW
a. 100% of charts reviewed which document that beneficiary received in-home CBE, include written documentation from the medical care provider stating why in-home CBE is needed.
b. 100% of charts reviewed which document that beneficiary received in-home CBE, indicate that at least ½ of the curriculum was covered.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

47. At a minimum, the CBE course outline found in the MIHP Operations Guide must be covered. The pregnant woman must attend at least ½ of the classes or cover ½ of the curriculum for the service to be billed. MIHP CBE may be billed one time per beneficiary per pregnancy. *(Section 3.1, Education Reimbursement, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of maternal charts reviewed which document that CBE classes are provided, indicate that the pregnant woman attends at least ½ of the classes or covers at least ½ of curriculum described in class schedule, before Medicaid is billed.
b. At least 80% of charts reviewed indicate that CBE is billed one time per beneficiary per pregnancy.

ON-SITE DOCUMENT REVIEW

c. Review of CBE course outline indicates that the required course content is being covered.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

48. At a minimum, the parenting education course outline found in the MIHP Operations Guide must be covered. The caregiver must attend at least ½ of the classes or cover ½ of the curriculum for the service to be billed. MIHP parenting education may be billed one time per infant or one time per family in the case of multiple births. *(Section 3.1, Education Reimbursement, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of infant charts reviewed which document that parenting education is provided, indicate that the beneficiary's caregiver attends at least ½ of the parenting education classes or covers ½ of the curriculum described in the class schedule, before Medicaid is billed.
b. At least 80% of infant charts reviewed which document that parenting education is provided, indicate that it is billed one time per infant or per family in the case of multiple births.

ON-SITE DOCUMENT REVIEW

c. Review of parenting education course outline indicates that the required course content is being covered.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

49. (Placeholder for indicator in next review cycle)

Children's Protective Services

50. The MIHP provider must work cooperatively and continuously with the local Children's Protective Services (CPS). Referral protocol and a working relationship with CPS must be developed and maintained. The MIHP provider must seek CPS assistance in a timely manner. *(Section 2.15, Special Arrangements for Child Protective Services, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

PRE-REVIEW MATERIALS

a. Protocol describes how provider:
   1) Reports possible child abuse or neglect to CPS in compliance with the Michigan Child Protection Law (Public Act 238 of 1975) by immediately calling Centralized Intake for Abuse and Neglect and submitting a written report (DHS 3200) within 72 hours of the call.
   2) Maintains a working relationship with CPS.

STAFF INTERVIEW

b. Staff interview indicates that staff can generally describe the protocol.

CHART REVIEW

c. 100% of charts reviewed which document possible child abuse or neglect, indicate on a *Professional Visit Progress Note (MIHP 011)* that immediate referrals are made to CPS.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Family Planning

51. Family planning options should be discussed throughout the course of care, giving the woman time to consider her options. *(Section 2.7, Professional Visits, MIHP, Medicaid Provider Manual)*.

To fully meet this indicator:

CHART REVIEW

a. At least 80% of charts reviewed indicate that family planning is discussed at every maternal visit with referrals to family planning services as needed, as documented on the *Professional Visit Progress Note (MIHP 011)*.
b. At least 80% of charts reviewed indicate that family planning is discussed with the mother or father (if he is the primary caregiver) at every infant visit unless the mother has undergone operative or non-operative permanent sterilization, or the mother or father (if he is the primary caregiver) refuses.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Immunization

52. Immunization status must be discussed throughout the course of care. Providers must determine the status of the MIHP beneficiary's (i.e., mother and/or child) immunizations. The parent(s) should be encouraged to obtain immunizations and be assisted with appointments and transportation as needed. *(Section 2.14, Immunizations, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of closed maternal charts reviewed indicate that mother's immunization status was discussed at least once, as documented on a *Professional Visit Progress Note (MIHP 011)*.
b. At least 80% of closed maternal charts reviewed indicate that infant immunizations are discussed at least once during pregnancy, as documented on a *Professional Visit Progress Note (MIHP 011)*.
c. At least 80% of infant charts reviewed indicate that the infant's immunization status was discussed at every visit, as documented on every *Professional Visit Progress Note (MIHP 011)*.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Referral Resource List

53. The MIHP must maintain a current list of local Public Health programs such as WIC Nutrition, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Community Mental Health (CMH), Children's Special Health Care Services (CSHCS), and other agencies that may have appropriate services to offer the beneficiary, and agree to work cooperatively with these agencies. *(Section 5.3, Operations and Certification Requirements, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

STAFF INTERVIEW

a. Staff interview indicates that staff can explain how they use the referral list and where it is located.

ON-SITE DOCUMENT REVIEW

b. Review of referral resource list indicates that it is current and includes 2-1-1- and local public health programs as well as other services and supports which may be helpful to MIHP beneficiaries.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Transportation Coordination

54. Transportation services are available to help MIHP-enrolled beneficiaries access their health care and pregnancy-related appointments. The MIHP provider should assess each MIHP beneficiary's needs and this assessment should be documented in the beneficiary's chart. Transportation is provided by the MIHP only when no other means of transportation are available. *(Section 2.10, Transportation, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

PRE-REVIEW MATERIALS

a. Protocol describes how:
   1) Transportation needs are assessed and documented for all beneficiaries.
   2) The beneficiary is referred to the appropriate resource (e.g., Medicaid Health Plan, local MDHHS) when a transportation need is identified.
   3) Transportation to medically-related services is provided for MHP beneficiaries by the MHP.
   4) Transportation is provided by the MIHP only when no other means are available.
   5) Transportation to medically-related services is arranged or provided for FFS beneficiaries by the MIHP.
   6) Non-medical transportation to pregnancy-related appointments is arranged or provided by MIHP for all beneficiaries, unless it is provided by the beneficiary's MHP.
   7) MIHP and the MHP coordinate transportation for all mutually served beneficiaries.

CHART REVIEW

b. At least 80% of charts reviewed which include the transportation domain in the *POC 2*, indicate that transportation was provided for the beneficiary and identify the provider in a *Professional Visit Progress Note (MIHP 011)*.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

55. (Placeholder for indicator in next review cycle)

Discharge Summary Reflecting Care Provided

***56. The discharge summary, including the services provided, outcomes, current status, and ongoing needs of the beneficiary, must be completed and forwarded to the medical care provider when the MIHP case is closed.** *(Section 2.16, Communications with the Medical Care Provider, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of closed charts reviewed include a *Maternal Discharge Summary (M200)* or *Infant Discharge Summary (I200)* that is complete and accurate with respect to each data field.

b. At least 80% of closed charts reviewed include a *Maternal Discharge Summary (M200)* or *Infant Discharge Summary (I200)* which reflects the *POC 2* and *Professional Visit Progress Note* documentation.
c. At least 80% of closed charts reviewed indicate that the *Discharge Summary* was sent to the medical care provider within 14 days of entering the *Discharge Summary* into the MDHHS database, as documented by *Medical Provider Maternal Discharge Summary Form C Cover Letter (M025)* or *Medical Provider Infant Discharge Summary Form C Cover Letter (I014)* in chart, unless the MIHP is part of an OB or pediatric practice and the MIHP agency has a signed statement indicating that notification is not necessary.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Transferring Beneficiary

---

57. The referring MIHP provider must consult with the new provider about the case and transfer necessary information or records in compliance with privacy and security requirements of Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. A copy of the completed Risk Identifier, POC, and visit notes must be shared with the new provider. Close coordination between providers should avoid duplication of services. A release of information from the beneficiary is necessary. *(Sec 2.13, Transfer of Care/Records, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

PRE-REVIEW

a. Protocol describes:
    1) The process for transferring an enrolled beneficiary to another MIHP provider, describing how agency will:
        a) Obtain *Consent to Transfer MIHP Record to a Different Provider* from beneficiary.
        b) Send the beneficiary's records (*Risk Identifier, Risk Identifier scoring results page, POC Parts 1-3*, and *Professional Visit Progress Notes*) to the receiving provider within 10 working days of the request.
        c) Refrain from completing a *Discharge Summary*.
        d) Refrain from providing copies of *Consent* forms signed at the time of MIHP enrollment to the receiving agency.
        e) Communicate appropriately and professionally with receiving provider to expedite the transfer in the beneficiary's best interest.
    2) The process for receiving a beneficiary who is transferring in from another MIHP provider, describing how agency will:
        a) Refrain from serving the beneficiary until the beneficiary's records are received from transferring MIHP, unless an emergency is documented.
        b) Contact the state consultant if the records are not received within 10 working days.
        c) File a copy of *Consent to Transfer MIHP Record to a Different Provider* in beneficiary's chart.
        d) Obtain *Consent to Participate in MIHP* and *Consent to Release Protected Health Information* from beneficiary.
        e) Notify the medical care provider that beneficiary has transferred to a different MIHP.
        f) Implement the transferred *POC*, using a new *Forms Checklist.*

3) Communicate appropriately and professionally with transferring provider to expedite the transfer in the beneficiary's best interest.

COORDINATOR INTERVIEW

b. Discussion with coordinator indicates that provider complies with transfer protocol when a beneficiary transfers to a new provider, sending the appropriate records (*Risk Identifier*, *Risk Identifier Score Sheet*, *POC Parts 1-3* and *Professional Visit Progress Notes*) to the new provider within 10 working days of the request.

CHART REVIEW

c. 100% of charts reviewed which document beneficiary transfer to another provider, include a complete and accurate (with respect to each data field) *Consent to Transfer MIHP Record to a Different Provider (Consent to Release Protected Health Information) (M402),* signed by the beneficiary and maintained on file after beneficiary information is sent to the new provider.
d. 100% of charts reviewed which document that the beneficiary was transferred to another MIHP provider, indicate that services were not billed after the transfer request was received.
e. At least 80% of charts reviewed which document that the beneficiary was transferred from another MIHP provider, indicate that the receiving provider obtained the beneficiary's information from the transferring provider before providing services to the beneficiary, except in an emergency situation which is documented in the chart.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Billing and Reimbursement

---

58. The MIHP provider must bill only the procedure codes listed in the MDHHS Maternal Infant Health Program Database located on the MDHHS website. *(Section 3, Reimbursement, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of charts reviewed indicate that the correct procedure code is used for billing each service provided.
b. At least 80% of charts reviewed indicate that there is a *Risk Identifier* or *Professional Visit Progress Note* on file for every *Risk Identifier* visit and professional visit billed.
c. At least 80% of charts reviewed indicate the date of service on each claim matches the date of service on the *Risk Identifier* or *Professional Visit Progress Note*.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Lactation Support Services

59. Medicaid will reimburse for evidence-based lactation support services provided to post-partum women in the outpatient setting up to and through 60 days post-delivery. Services must be rendered by a licensed, qualified health professional. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service. (Medicaid Coverage of Lactation Support Services, Medicaid Provider Manual, Bulletin Number MSA 15-46)

To fully meet this indicator:

CHART REVIEW

a. 80% of charts reviewed that indicate lactation support services were conducted and billed separately from the other nine maternal visits, show the HCPCS code S9443 was used on the paid claim, and the claim was billed to the mother's Medicaid ID.
b. 80% of charts reviewed that indicate MIHP lactation support services were conducted and billed separately show the *IBCLC Professional Visit Progress Note* was used and was complete and accurate.
c. 80% of charts reviewed that indicate lactation support services were conducted and billed separately show services were rendered by an IBCLC credentialed MIHP registered nurse or licensed social worker and that the IBCLC certification is valid and current.
d. 80% of the charts reviewed that indicate lactation support services were conducted and billed separately document a need for maternal lactation support.
e. 80% of the charts reviewed that indicate lactation support services were conducted and billed separately document the initial assessment visit, appropriate *Risk Identifier* (infant or maternal) and *Plan of Care* (infant or maternal) is completed and the *Risk Identifier* is entered into the MIHP database.
f. 80% of the charts reviewed that indicate lactation support services were conducted and billed separately document that comprehensive lactation counseling services included at a minimum:
    1) Face-to-face encounter with the beneficiary lasting a minimum of 30 minutes.
    2) Provision of evidence-based interventions that, at a minimum, include:
        i. Instruction in positioning techniques and proper latching to the breast.
        ii. Counseling in nutritive suckling and swallowing, milk production and release, frequency of feedings and feeding cues, expression of milk and use of pump if indicated, assessment of infant nourishment, and reasons to contact a health care professional.
        iii. The provision of community support resource referrals, such as the Women, Infants and Children (WIC) program, as indicated.
    3) Evaluation of outcomes from interventions.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Billing and Reimbursement

---

60. The Risk Identifier is required to be completed and entered into the MIHP database before the service is billed. *(Section 3, Reimbursement, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of charts reviewed indicate that *Risk Identifier* is completed and entered into the database before the service is billed.

ON-SITE DOCUMENT REVIEW

b. Protocol describes:
    1) Process for entering *Risk Identifiers* into the MIHP database, specifying who is responsible for data entry.
    2) Number of days that persons responsible for data entry have to complete data entry and obtain scoring results page after *Risk Identifier* is administered.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

61. Reimbursement for a professional visit is based on place of service. The place of service must be documented in each professional visit note and billed accordingly. *(Section 3, Reimbursement, MIHP, Medicaid Provider Manual)*

To fully meet this indicator (which has billing implications):

CHART REVIEW

a. At least 80% of charts reviewed indicate that the place of service code used when billing for the *Risk Identifier* correctly reflects the place of service documented on the *Risk Identifie*r.
b. At least 80% of charts reviewed indicate that the place of service code used when billing for professional visits correctly reflects the place of service documented on the *Professional Visit Progress Note*.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

62. An infant case and a maternal case can both be open at the same time in some incidences. If the MIHP is seeing an infant and the mother becomes pregnant, a maternal risk identifier assessment visit can be completed and billed as such. After this initial risk identifier assessment visit is completed, all subsequent professional visits for that family should be blended visits and billed under one Medicaid ID. The program is based on the family dyad, and both the infant and parent are to be assessed at each visit and billed as "blended visits" under either the parent's or the infant's Medicaid ID. *(Section 1.3 Eligibility, MIHP, Medicaid Provider Manual)* **Transportation services may be billed under the mother's ID for the pregnant woman and under the infant's ID for the infant.** *(Section 2.10, Transportation, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of charts reviewed indicate that blended visits are consistently billed under the mother's Medicaid ID or the infant's Medicaid ID, and not under both.
b. At least 80% of charts reviewed indicate that transportation services for the pregnant woman are billed under her Medicaid ID and transportation services for the infant are billed under the infant's Medicaid ID.
c. At least 80% of charts reviewed have *Notification of Multiple Charts Open (099)* on file in both the maternal chart and the infant chart when blended visits are being provided unless a family chart is used.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

63. (Placeholder for indicator in next review cycle)

64. The MIHP provider must maintain documentation of transportation for each beneficiary for each trip billed. *(Section 2.10, Transportation, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

CHART REVIEW

a. At least 80% of charts reviewed indicate that transportation services are provided to allowable destinations only and are appropriately billed and paid.
b. At least 80% of charts reviewed indicate that transportation services are documented for each beneficiary for each trip billed, incorporating all required elements.
c. At least 80% of charts reviewed indicate that provider does not provide medical transportation for MHP members.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

65. The initial assessment visit and up to 9 professional visits per woman per pregnancy are billable. *(Section 2.1, Maternal Risk Identifier, MIHP, Medicaid Provider Manual)*. **The initial assessment visit and up to 9 professional visits per infant/family are billable.** *(Section 2.2 Infant Risk Identifier, MIHP, Medicaid Provider Manual)*

To fully meet this indicator:

STATE MIHP STAFF ADMINISTRATIVE REVIEW

a. At least 80% of charts reviewed indicate one *Maternal Risk Identifier* per pregnancy or one *Infant Risk Identifier* per infant is billed and paid.
b. At least 80% of maternal charts reviewed indicate no more than 9 professional visits are billed and paid.
c. At least 80% of infant charts reviewed indicate no more than 36 infant visits are billed and paid.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Quality

---

66. MIHP coordinators are expected to routinely conduct their own internal quality assurance activities, including chart reviews and billing audits. *(Internal Quality Assurance, Chapter 9, MIHP Operations Guide)*

To fully meet this indicator:

ON-SITE DOCUMENT REVIEW

a. Protocol:
    1) Describes internal quality assurance activities.
    2) Specifies that chart reviews and billing audits are conducted quarterly, or more frequently.
    3) Specifies which staff position(s) performs chart reviews and billing audits.
    4) Indicates the minimum number of charts reviewed per chart review and per billing audit.
    5) Describes how staff are trained and supported to ensure that the *Risk Identifier, POC, Professional Visit Progress Notes*, and *Discharge Summaries* are linked.
    6) Describes how staff works with the beneficiary to identify her needs at program entry and periodically asks beneficiary if services being provided are meeting her needs.

STAFF INTERVIEW

b. Staff interview indicates that staff can generally describe the protocol.
c. Staff interview indicates that staff can explain how the *Risk Identifier*, *POC*, *Professional Visit Progress Notes*, and *Discharge Summaries* are linked.

ON-SITE DOCUMENT REVIEW

d. Review of completed forms, checklists or other tools used in the last quarter's internal chart review and billing audit, indicates that reviews and audits are being conducted.

☐ Met ☐ Not Met ☐ Met with Conditions ☐ Not Applicable

Findings:

Overall Comments

1.	Use of standardized forms
2. *	Sufficiently detailed clinical record
3.	Signed consents
4.	Requested Medical Records Are Available
5.	*Maternal and Infant Discharge Summaries* entered into database
6.	OB-based maternal-only programs: provision of maternal home visits and infant services
7.	Staff requirements
8.	*MIHP Personnel Roster*
9.	Physician order required for registered dietitian
10.	Nutrition counseling services
11.	MIHP services provided through contract or letter of agreement with another agency
12.	*Care Coordination Agreements* with Medicaid Health Plans
13.	Physical facilities for seeing beneficiaries
14.	MIHP office in provider residence or other location where beneficiaries are not seen
15.	Reporting MIHP enrollment to Medicaid Health Plan
16.	Confidential (HIPAA compliant) beneficiary record system
17.	Beneficiary grievances
18.	Emergency Services and Scheduling Services to Accommodate Beneficiary
19.	Accommodations for Limited English Proficient, deaf and hard of hearing, and blind and visually impaired persons
20.	Outreach to target population and medical providers
21.	Prompt response to receipt of referral
22.	Medical care provider notified within 14 days of beneficiary enrollment
23.	Medical care provider notified when a significant change occurs
24.	*Risk Identifier* completed to determine needed services/Authorization to provide services if no need indicated on *Risk Identifier*
25.	Linkage to Early On Interagency Coordinating Council and Great Start Collaborative
26. *	Developmental screening for all infant beneficiaries using *Bright Futures* and *ASQ-3* and *ASQ: SE-2*
27. *	*Plan of Care (Parts 1-3)*
28.	Care coordinator identification
29.	Care coordination and care coordinator chart review
30.	Making and following-up on referrals
31.	(Placeholder for indicator in next review cycle)
32.	Address domains scoring high risk in first three visits and development of safety plans
33.	Professional visits to implement beneficiary's *Plan of Care*
34.	On average, 80% of professional infant interventions in beneficiary's home; initial assessment visit in home 90% of the time
35.	Additional nine infant visits when requested by medical care provider
36.	Drug-exposed infant visits and procedure code
37.	Multiple births (blended visits)
38.	Timely submission of pre-review documents via mail
39.	Number of staff present for interview
40.	Identification cards or badges
41.	Community visits
42.	Maternal prenatal and postpartum home visit

43.	Dissemination of information to professional and administrative staff
44.	Training requirements
45.	First-time mothers encouraged to complete childbirth education course
46.	Childbirth education in beneficiary's home in unusual circumstances
47.	Childbirth education course
48.	Parenting education course
49.	(Placeholder for indicator in next review cycle)
50.	Children's Protective Services
51.	Family planning discussed at every maternal visit
52.	Immunization status discussed throughout course of care
53.	Referral resources list
54.	Transportation coordination
55.	(Placeholder for indicator in next review cycle)
56. *	*Discharge Summary* completed and send to medical care provider
57.	Transferring beneficiary
58.	Use of billing procedure codes listed in MDHHS MIHP database
59.	Lactation Support Services
60.	*Risk Identifier* entered into database before service is billed
61.	Place of service documented in professional visit note and billed accordingly
62.	Infant and maternal cases open at the same time in some instances (blended visits)
63.	(Placeholder for indicator in next review cycle)
64.	Transportation documentation for each beneficiary for each trip billed
65.	Initial assessment and up to 9 professional visits per pregnancy or per infant/family billed
66.	Internal quality assurance

***MIHP Critical Indicator**